Helpful Hints About Completing the Form:

Demographic Information

- Be sure to include your Federal Tax Identification Number and your State Tax ID – both can be found on your tax returns, quarterlies, etc.
- Eligible employees are those employees who work more than 30 hours per week (or lower if the employer chooses)

Help with the questions

Q1 – Please list the number of employees who are eligible for the participation in your company's health insurance or who will be eligible if you choose to provide coverage under this program.

By rule, you must have between 2 and 5 employees including owners, if participating – the program doesn't allow groups of fewer than 2 or more than 5 to participate.

Q2 – Related employers are defined as those persons having a relationship (parents, siblings, and spouse) and who own another business or part of another business. For further information or if you think this may apply, please contact your tax preparer or the Department of Revenue.

Q3 – This question only pertains to employees – not the owners – to qualify no employee may earn over $75,000 per year in gross income from the employer. Outside income from your business doesn't count toward this income level.

Q4 – Having a tax delinquency may bar your company from participation unless that delinquency will be resolved by January 1, 2006

Q5 – The answer to this question is important. If you've provided group health insurance at any time in the last 24 months to eligible employees you will only qualify for the tax credit section of this program (complete the Tax Credit Section). If you haven't provided insurance for your employees in this time period you may be eligible for the new purchasing pool and should complete the Insurance Pool Section.

THE EMPLOYER APPLICATION FORM MUST BE FILLED OUT COMPLETELY AND SUBMITTED TO THE STATE AUDITOR'S OFICE IN ORDER TO QUALIFY FOR THE PROGRAM.

Montana Healthcare Affordability Act Background:

EMPLOYER REFUNDABLE (ANNUAL) TAX CREDITS

For currently insured small businesses:

This program will provide a refundable state income tax credit to employers who currently pay some or all of the cost of group health insurance for their employees. It will also provide additional Tax Credits when employers pay for insurance for the employee's spouse or their dependants. Approximately 40% of the available funding per year is designated to the Employer Tax Credit. The funds for tax credits will be distributed on a first come, first served basis until the money is fully allocated. The tax credit amounts are $100 per

employee per month of coverage if the average age of the employees is under 45 years of age. For employers with an average age of 45 and over the tax credit is $125 per employee per month of coverage.

PREMIUM ASSISTANCE AND INCENTIVE PAYMENTS

For currently uninsured small businesses:

Description: Provides a monthly assistance payment for both the employer and the employee's portion of the health insurance premium. This assistance will pay the cost of an employee's health insurance when the employer has not offered insurance in the past, but begins to do so through the new State Health Insurance Purchasing Pool created by HB 667, or through a qualified Association Plan. About 60% of the available funding is designated to provide these Employee Assistance Payments and Employer Premium Incentives. The funds will be distributed on a first come, first served basis. The amount of the employer premium incentive payment and each employee's premium assistance payment will be established by the Purchasing Pool Board of Directors.

Employer/Employee Qualifications: To qualify for Premium Incentive and Assistance Payments employers and employees must meet the following criteria:

The employer does not currently provide employee health insurance,

The employer has a number of employees that meets the eligibility criteria established by the State Auditor's Office (between 2–5 employees; adjustable up to 9 depending on take-up and available revenue),

The employer begins to provide health insurance through the new State Health Insurance Purchasing Pool or another qualified Association Plan,

No employee is paid more than $75,000 per year (owner excluded),

The employer provides health insurance to eligible employees as defined by the State Purchasing Pool Board of Directors, and

Employees meet the income and other eligibility criteria established by the Board of Directors of the Purchasing Pool.

FUTURE ENROLLMENT INFORMATION:

Businesses will re-enroll each October for both the tax credits and the premium payments. If your business enrolls the first year and is determined to be eligible, but the slots for the program are filled, then your business will be placed on a waiting list. Those businesses on the waiting list will also be required to re-enroll each year. The re-enrollment period will occur October 1-31. Those businesses already enrolled in the program or that were previously on the waiting list will be given preference before new members are added.

As long as your business doesn't grow past 9 full-time employees, you will still be eligible to receive tax credits or premium assistance and incentive payments, and participate in the purchasing pool. For example, if you register 4 full-time employees this year, and your business grows to 7 full-time employees next year, you will still be able to receive assistance for the 4 full-time employees upon re-enrollment, as long as there is available revenue. If your business grows past 9 full-time employees, then you will no longer be eligible for the incentive/assistance payments (or tax credits), but can still maintain membership in the purchasing pool.

MONTANA STATE AUDITOR
JOHN MORRISON
COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES
840 Helena Ave. ♦ Helena, MT 59601 ♦ 800-332-6148

EMPLOYER APPLICATION

Montana Small Business Health Care Affordability Act

Please complete and return to: **Montana State Auditor's Office**
840 Helena Avenue
Helena, MT 59601
Fax: 406-444-3497

Applications available in September and accepted on a first come, first serve basis beginning 10/01/2005. Each year the number of applicants admitted to the program is dependent upon available revenue from cigarette taxes. Funding and sustainability of the Small Business Health Insurance program is determined on an annual basis. You will be notified by mail of your acceptance into the plan or your position on the waiting list. For more info call 1-800-332-6148 or log on to sao.mt.gov.

Demographic Information (must be complete)

Legal Name of Firm	Type of Entity	Business Start Date	Federal Tax ID Number

Contact Name and Title	Company Name to Appear on Statement	Type of Business

Address	City	State	Zip Code

Mailing Address if Different	City	State	Zip Code

Telephone	Fax	Email Address	State Tax ID

Please List Any Additional Company Names (DBA's)

Number of Employees	Estimated Number of Eligible Employees*	Number of Employees and Owners who wish to participate

*"Eligible Employee," (provided for in Montana Code Annotated 33-22-1803): "means any employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees." The owner of a business can be included as an employee and a member of the group.

Please answer the following questions.

1. How many employees do you wish to insure through a purchasing pool or cover with the tax credit? _____
   If you answered less than 2 or more than 5 employees, you don't qualify. **STOP**

2. If applicable, please fill out the related employer information below.

Please list any related employers	Federal Tax ID Number

Please include the following information for all related employers

Number of Employees	Estimated Number of Eligible Employees*

3. Do any of your employees or employees of a related employer earn over $75,000 per year (excluding owners)?
   Yes ___ No ___
   If you answered yes, you don't qualify **STOP**

4. Does your firm or any related employers have delinquent state individual income or corporation license taxes?
   Yes ___ No ___
   If "Yes", list the tax years and type of delinquent taxes. _____
   If "Yes", will the delinquencies be paid prior to January 1, 2006? Yes ___ No ___

5. Has your business provided group health insurance in the past 24 months? Yes ___ No ___
   If you answered yes to line number 5, go to number 11 (tax credits section on the back of this form) otherwise go to number 6 (insurance pool section on the back of this form).

PLEASE CONTINUE ON THE BACK OF THIS FORM

Insurance Pool Section

6. Is your business planning on applying for premium assistance and premium incentive payments and then participating in the Small Business Health Insurance Pool? Yes ___ No ___

   Or obtaining group health insurance through an association health plan? Yes ___ No ___

   If yes, which association health plan _____

7. Please estimate the number of participants that may be covered under this plan in the following categories:
   Dependent Children under 19 years of age _____

   Single adults (employees) 19 or 20 years of age _____

   Employees' Spouses _____

   Please estimate the ages of the spouses ____ ____ ____ ____ ____

8. What are the ages of your employees? ____ ____ ____ ____ ____

9. Will the employer be contributing to premiums for dependents? Yes ___ No ____

10. Please sign at the bottom of the form and submit. **SIGN**

Tax Credits Section

11. Do you currently sponsor a small group health plan? Yes ____ No ____

12. Who is your current group health insurance company _____

    Policy Number_____

    Insurance company contact telephone number _____

    Do you pay premiums from a medical care savings account? Yes ____ No ____

13. What is the total premium paid for group health insurance per employee per month? _____

    What are the ages of your covered employees? ____ ____ ____ ____ ____

14. Are you paying for employee spouses or dependents? If yes, how much is the employer contribution for spouses? _____
    How much is the employer contribution for eligible dependents? _____

    What are the ages of the covered spouses and dependents? ____ ____ ____ ____ ____

15. Please sign at the bottom and submit. **SIGN**

By my signature below, I authorize my current health insurer to disclose to the State Auditor's Office all information relating to any health insurance premiums paid for this employer group, as well as any information pertaining to the number of employees and dependents covered under the employer group health plan that I sponsor. This authorization shall remain valid for as long as I continue to receive the tax credits and/or premium incentive/assistance payments referenced in this registration form.

I agree that if I change my health insurance plan, or if the number of employees and dependents that are covered under this health plan changes, I will notify the State Auditor's Office within 30 days.

Employer Signature _____ **Date** _____